MOLINA HEALTHCARE
Your Extended Family

Span of Coverage Policy Clarification

The purpose of this notice is to clarify the Span of Coverage policy for hospital transfers. The language describing span of coverage varies among the managed care contracts. However, the underlying policy is the same.

Span of Coverage refers to the payment responsibility for hospital facility charges when there are Medicaid enrollment changes during the hospital stay. This policy does not apply to CHIP.

Summary of Policy

A Medicaid enrollment change is any change in managed care enrollment, including:

- Member moves from fee-for-service (FFS) to managed care
- Member moves from managed care to FFS
- Member moves between managed care organizations (MCOs) in the same managed care program (i.e., STAR, STAR+PLUS, STAR Kids, STAR Health)
- Member moves between managed care programs

When an enrollment change occurs while a member is in the hospital, the previous payer (former MCO or FFS) remains responsible for the hospital facility charge until discharge, transfer, or loss of Medicaid eligibility. The current payer (new MCO or FFS) is responsible for all other covered services beginning on the effective date of the enrollment change.

Scenario	Hospital Facility Charge	All Other Covered Services
Member retroactively enrolled in managed care	New MCO	New MCO
Member prospectively moves from FFS to managed care	FFS	New MCO
Member moves from managed care to FFS	Former MCO	FFS
Members moves between MCOs in the same program	Former MCO	New MCO
Member moves between MCO programs	Former MCO	New MCO

STAR and STAR+PLUS

The Span of Coverage sections of the Uniform Managed Care Contract, STAR+PLUS Expansion Contract, and STAR+PLUS MRSA Contract are specific to stays in a single hospital without transfers. The contract define "discharge" and "transfer" as follows:

- Discharge means a formal release of a Member from an Inpatient Hospital stay when the need for continued care at an impatient level has concluded. Movement or Transfer from one (1) Acute Care Hospital or Long Term Care Hospital/facility and readmission to another within 24 hours for continued treatment is not a discharge under this Contract.
- Transfer means the movement of the Member from one (1) Acute Care Hospital or Long Term Care Hospital/facility and readmission to another Acute Care or Long Term Care Hospital within 24 hours for continued treatment.

When there is a hospital transfer, the Span of Coverage section no longer applies. At that point, Section 8.1.2 of the contract applies: "The MCO is responsible for assessing, authorizing, arranging, coordination, and providing Covered Services […] in accordance with the requirements of the contract. The MCO must provide Medically Necessary Covered Services to all Members beginning on the Member's date of enrollment regardless of pre-existing conditions, prior diagnosis and/or receipt of any prior health care services."

STAR Kids, STAR Health, and Dual Demonstration

The STAR Kids, STAR Health, and Dual Demonstration contracts do not define "discharge" or "transfer." For the purposed of the Span of Coverage sections of these contracts, "discharge" includes transfer.

Authorization of Hospital Transfers

If the member is in FFS at the time of the transfer request, the Texas Medicaid & Healthcare Partnership (TMHP) is responsible for making the authorization determination for transfer to the second hospital.

If the member is in managed care at the time of the transfer request, the MCO with which the member is enrolled at the time of the transfer request is responsible for making the authorization determination for transfer to the second hospital.

If there is an enrollment change between the date of authorization and the date of transfer, the new MCO must honor the authorization of the previous payer (FFS or former MCO) in accordance with the continuity of care requirements in the managed care contracts.

Reimbursement Coordination Between Payers

The two payers must coordinate payments to the hospitals in accordance with client transfer policy outlined in the Texas Medicaid Provider Procedures Manual (TMPPM), Inpatient and Outpatient Hospital Services Handbook, Section 3.7.32, "Client Transfers."

Example

- 10/1 – Member is enrolled with MCO A
- 10/25 – Member is admitted to Hospital 1
- 11/1 – Member changes enrollment to MCO B
- 11/15 – Member transfers to Hospital 2

MCO A is responsible for:

- All covered services from 10/1 through 10/31
- Hospital 1 facility charges from 11/1 through 11/15

MCO B is responsible for:

- All covered services except the Hospital 1 facility charge from 11/1 through 11/15
- All covered services, including the Hospital 2 facility charge, beginning on 11/15

MCO A and MCO B must coordinate the reimburse the hospitals in accordance with Medicaid policy as described in the TMPPM Inpatient and Outpatient Hospital Services Handbook, Section 3.7.3.2, "Client Transfers."

If you have any questions on this policy clarification or appropriate billing, please contact your Provider Services Representative or contact the Provider Services Department by calling (855) 322-4080, Monday through Friday, 8 a.m. – 5 p.m., central time or emailing MHTXProviderServices@MolinaHealthcare.com.